

Brent Urgent Care Centre (Care UK Clinical Services Limited)

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Requires improvement 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Brent Urgent Care Centre (Care UK Clinical services Limited) on 16 March 2016. Overall the service is rated as good.

Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and an effective system in place to report and record significant events. Staff knew how to raise concerns and understood the need to report incidents.
- All incidents were recorded on the electronic incident recording system which enabled an organisation-wide overview. Learning was based on a thorough analysis and investigation of any errors and incidents.
- The provider maintained a risk register and held regular local and organisational governance meetings. Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.

- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the service complied with these requirements.
- The service had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Although the provider demonstrated a good understanding of the service's performance and was meeting the majority of its performance targets, it had failed to achieve for a 12-month period the performance target to triage and determine the care pathways for children and adults within the specified timeframes.
- Patient feedback indicated that patients were treated with care and respect and were involved in decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- The service was accessible 24 hours every day. Patient feedback was positive about the ease of using the service and time taken to receive treatment.

Summary of findings

- The service had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure at organisational and local level and staff told us they felt supported by management. The service proactively sought feedback from staff and patients, which it acted on.

The areas where the provider must make improvement are:

- Ensure failing performance targets are monitored and improved to mitigate the risks to the health and safety of patients receiving care and treatment.

The areas where the provider should make improvement are:

- Ensure all staff understand, and continue to understand, the fire evacuation plan.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The service is rated as good for providing safe services.

Good



- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the service. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The service had clearly defined and embedded systems, processes and services to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The service had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

The service is rated as requires improvement for providing effective services.

Requires improvement



- Although the provider demonstrated a good understanding of the service's performance and was meeting the majority of its performance targets, the service had failed to achieve for a 12-month period the target of 95% to triage and determine the care pathway for children within 15 minutes of arrival and 20 minutes for adults.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

The service is rated as good for providing caring services.

Good



- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Summary of findings

- The service received consistently positive patient feedback from its monthly survey.
- Patients who we spoke with and those who completed comments cards said that the provider offered an excellent, prompt and efficient service and that staff were helpful and caring.
- Information for patients about the services available was accessible and available in several languages.

Are services responsive to people's needs?

The service is rated as good for providing responsive services.

- The provider reviewed the needs of patients and engaged with the clinical commissioning group to secure improvements to services where these were identified.
- The urgent care centre was open 24 hours a day and seven days a week. It was accessible to patients with mobility difficulties. There were accessible facilities, an induction hearing loop and interpreter services.
- Children were assessed as a priority and the facility had designated children's seating and treatment area. Baby changing and breast feeding facilities were available.
- The majority of the feedback from patients we spoke with and the comment cards indicated that the provider ran a prompt service.
- Information about how to complain was available and easy to understand and evidence showed the provider responded promptly and openly to issues raised. Learning from complaints was shared with staff, organisation-wide and with other stakeholders.

Good



Are services well-led?

The service is rated as good for being well-led.

- The provider had a clear vision and strategy to deliver high quality care and promote good outcomes for patients attending the urgent care centre.
- There was a clear leadership structure and staff felt supported by management. The service had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.

Good



Summary of findings

- The provider was aware of the requirements of the duty of candour.
- The service proactively sought feedback from staff and patients and we saw examples where feedback had been acted on.
- There was a focus on continuous learning and improvement at all levels.

Summary of findings

What people who use the service say

As part of our inspection we also asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received 11 comment cards of which 10 were positive about the standard of care received. Patients commented that the provider offered an excellent, prompt and efficient service and that staff were helpful and caring. The one negative comment was about the waiting time to be seen but it was unclear at what time of the day the patient was accessing the service and whether this was a period of high demand.

We spoke with three patients during the inspection. Two of the patients had attended the centre previously and for one it was the first time. All three patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. All the patients we spoke with were accessing the service during a period of low demand.

Areas for improvement

Action the service **MUST** take to improve

- Ensure failing performance targets are monitored and improved to mitigate the risks to the health and safety of patients receiving care and treatment.

Action the service **SHOULD** take to improve

- Ensure all staff understand, and continue to understand, the fire evacuation plan.

Brent Urgent Care Centre (Care UK Clinical Services Limited)

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Brent Urgent Care Centre (Care UK Clinical Services Limited)

Brent Urgent Care Centre (UCC) is commissioned by Brent Clinical Commissioning Group (CCG) to provide an urgent care service within the north west London borough of Brent. The service is located within the Central Middlesex Hospital (run by London North West Healthcare NHS Trust) and occupies the space of the former A&E department which closed in September 2014 and transferred to Northwick Park Hospital.

The service is provided by Care UK Clinical Services Limited which provides centralised governance for the service. On site the service is led by a service manager, a lead GP and a lead nurse who have oversight of the urgent care centre and a team of substantive and self-employed doctors, nurses, administration and reception staff.

The urgent care centre is open 24 hours a day, seven days a week including public holidays. No patients are registered at the service as it is designed to meet the needs of patients who have an urgent medical concern but do not require accident and emergency treatment, such as non-life threatening conditions. Patients attend on a walk-in basis. Patients can self-present or they may be directed to the service, for example by the NHS 111 or their own GP. Patients presenting to the service are 'streamed' by a clinical co-ordinator to determine the urgency and nature of their presenting complaint. The urgent care centre sees on average 740 patients per week.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We had previously inspected Brent Urgent Care Centre in February 2014 and found at that time that the provider met all essential standards.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations including the clinical commissioning group to share what they knew. We carried out an announced visit on 16 March 2017.

During our visit we:

- Spoke with a range of staff including the service manager, the lead GP, the lead nurse, one of the duty GPs, an advanced nurse practitioner, an emergency care practitioner, an administrator and two receptionists.
- Observed how patients were greeted on arrival and spoke with patients (and their family members) who had received treatment at the urgent care centre.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

- Inspected the facilities, equipment and premises.
- Reviewed a wide range of documentary evidence including the service contract, policies, written protocols and guidelines, recruitment and training records, safeguarding referrals, significant events, patient survey results, complaints, meeting minutes and performance data.
- Reviewed a sample of 11 anonymised treatment records of patients.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Are services safe?

Our findings

Safe track record and learning

There was an effective system for reporting and recording incidents. We saw that the provider recorded all incidents on an electronic risk management software tool.

- Staff told us they would inform the service manager or on-call manager of any incidents and enter them on the electronic recording system. Staff had access to an operational policy and process flowchart. The system supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Staff we spoke with were familiar with the duty of candour and their responsibility to be open with patients. We noted that clinical staff had undertaken duty of candour training.
- In the last year the provider had reported 49 incidents. These had been analysed and categorised, for example clinical incidents, IT issues, medicine incidents and incidents involving aggressive or violent patients. We saw that the provider had carried out a thorough analysis of all incidents.
- There were recent examples of improvement and learning from incidents. For example, the provider was automating its 'to take out' (TTO) medicines stock controls after several incidents where stock had not been adjusted on the manual system when dispensed to patients.
- Any serious incidents from the service were reviewed centrally by Care UK Clinical Service Limited and any learning from these was shared with staff at the service through emails and a newsletter. We saw evidence of learning from a drug interaction in the latest edition.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received an explanation and a written apology and were told about actions taken to prevent any recurrence.
- The provider maintained a risk register and held regular local and organisational-wide governance meetings.
- Incident reporting and outcomes were part of the monthly governance report provided to Care UK. We saw evidence that incidents and significant incidents

were discussed and shared at a regional level through the London regional quality assurance meeting, which included service managers from urgent care services and out-of-hours services within the Care UK portfolio.

The provider had a central alert system (CAS) policy and process in place for the dissemination of safety alerts, for example Department of Health, NHS Estates and Medicines and Healthcare products Regulatory Agency (MHRA). We were told that all alerts were cascaded from Care UK to the service leads by email and added to local CAS log on the providers intranet. The service leads determined whether the alert was relevant, identify whether action was required, what action should be taken and update the CAS log. Alerts relevant to the service were emailed to staff. As part of the Care UK governance systems, the CAS alert process was audited twice a year to ensure compliance. Staff we spoke with confirmed they received alerts and there was an electronic manual central file of all alerts. Alerts were also discussed at regional quality assurance meetings.

Overview of safety systems and processes

The provider had clearly defined and embedded systems, processes and services in place to minimise risks to patient safety.

- There were arrangements in place to safeguard children and vulnerable adults from abuse which reflected relevant legislation and local requirements. The lead GP and the lead nurse were the designated safeguarding leads for children and adults.
- We saw evidence of regular safeguarding meetings with a health visitor liaison from the paediatric and maternity liaison service. The safeguarding lead nurse attended local safeguarding children board sub-group meetings and multi-agency risk assessment conferences. The provider also held quarterly meetings for all its safeguarding leads within the organisation.
- We reviewed the local safeguarding children and safeguarding adult policies and saw that they were in-date and had been reviewed recently to reflect a change which had been made to a referral form. The policies were accessible to staff and clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. All staff we spoke with knew who the safeguarding leads were.
- We observed safeguarding key contact details, referral flowcharts and guidance on the mandatory reporting of

Are services safe?

female genital mutilation in girls under 18 displayed in consultation and treatment rooms. In addition, the clinical system had an automatic 'safety net' check list for all children seen up to the age of 18. The patient record could not be closed unless the clinician had considered and ticked off the list.

- The provider had made 89 safeguarding referrals in the last 12 months of which 79 were child and 10 adult referrals. All safeguarding referrals were also logged in the provider's recording system which provided an organisational overview.
- Staff demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. We saw evidence that both safeguarding leads had received external safeguarding level four training, clinical staff had been trained to safeguarding level three and non-clinical staff to level two. All staff had undertaken safeguarding adults and Prevent (anti-radicalisation) training.
- A notice in the waiting room and consultation rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- On presenting at the urgent care centre the patient was reviewed by a qualified clinical co-ordinator who determined the care pathway route.

The service maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. The Central Middlesex Hospital's cleaning team was responsible for cleaning the urgent care centre. A domestic cleaner was assigned to the urgent care centre throughout the day and we saw evidence of this during our inspection. There were cleaning schedules and monitoring systems in place.
- The lead nurse was the infection prevention and control (IPC) clinical lead. Monthly IPC audits were undertaken and submitted to Care UK as part of its governance processes. We saw evidence that action was taken to address any improvements identified as a result, for example the replacement of an examination couch

which was found to have torn fabric. There were infection control policies in place covering handwashing, the safe handling of sharps and spillages. We observed that each consulting room had information displayed on good handwashing techniques and how to deal with a sharps injury and was well equipped with personal protective equipment and waste disposal facilities. There was a dedicated 'dirty' utility room (for the disposal of all soiled and contaminated items to reduce the spread of infection) which we observed was used appropriately. All staff had received up-to-date IPC training. All non-clinical staff we spoke with knew how to handle specimens on reception and had access to appropriate personal protective equipment when handling specimens at the reception desk.

The arrangements for managing medicines, including emergency medicines and vaccines, in the service minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- Care UK had a lead pharmacist who cascaded medicines information to the urgent care centre via the service manager and clinical leads. All medicines ordering was undertaken by the lead nurse from one medicines supplier. We saw an ordering of medicines policy and reviewed ordering proforma and stocks of 'to take out' (TTO) medicines for patients, which are commonly used pre-packed and pre-labelled medicines. We checked a selection in the storage area and all were found to be within their expiry date. The provider told us they were about to 'go live' with an automated stock control for its TTO medicines linked to their clinical system. This would enable a more efficient medicines management system and reduce the risk of error in stock control from the current manual system.
- There were systems for managing medicines for use in an emergency in the urgent care centre. Records were maintained of medicines used and signed by staff to maintain an audit trail. The medicines were stored securely in a locked area and medicines which required refrigeration were stored in refrigerators the temperatures of which were monitored to help ensure their effectiveness. Access to medicines was limited to specific staff. There was evidence of stock rotation and medicines we checked at random in the storage areas were all within date. However, we did find some

Are services safe?

dressings out-of-date on clinical trollies in two consultation rooms. The provider contacted us immediately after the inspection to advise us they had reviewed all its clinical trollies and found further dressings out-of-date. Although the trollies were on their monthly schedule of checking drugs and consumables it had decided that satellite trollies posed a risk and had changed its policy to hold minimal stock in key treatment rooms. Stock when required would be taken from a central stock room.

- The urgent care centre held a stock of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and we saw they had procedures in place to manage them safely. For example, controlled drugs were stored in a controlled drugs cupboard, access to them was restricted, keys were held securely and there was a controlled drugs register. There were arrangements in place for the destruction of controlled drugs. The Care UK lead pharmacist was the Controlled Drugs Accountable Officer (CDAO). We saw the lead nurse had circulated a prescribing bulletin outlining controlled drug recording requirements. The process was regularly audited.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use. All prescription printers were locked.
- Patient Group Directions had been adopted by the service to allow non-medical prescribers to administer medicines in line with legislation.

We reviewed five substantive staff files and two self-employed staff files, which included clinical and non-clinical personnel, and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- The premises were managed by the Central Middlesex Hospital's facilities management team. We were able to inspect various maintenance schedules and risk assessments to monitor safety of the premises such as control of substances hazardous to health and

Legionella (Legionella are bacteria that can contaminate water systems in buildings). We saw evidence of regular water sampling to monitor the risk of Legionella. The provider had also undertaken its own health and safety risk assessments within the unit.

- There was an up-to-date fire risk assessment and fire alarms were tested on a weekly basis. There was a designated and trained fire marshal within the service. All staff had undertaken fire awareness training. We observed clear information and signage throughout the facility for staff and patients on what to do in the event of a fire and how to exit the building. Staff we spoke with knew the location of the fire evacuation point. However, there had not been a fire evacuation drill in the past 12 months.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order and we saw evidence that portable appliance testing had been undertaken in May 2016 and clinical equipment had been calibrated in September 2016.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The service had adequate arrangements to respond to emergencies and major incidents.

- The urgent care centre was located within a hospital setting and operated within its emergency response protocol through the standard crash call telephone number. All staff we spoke with were aware of the system. The provider had worked closely with the anaesthetic staff who led the hospital resuscitation team to ensure a coordinated and safe response to emergencies. The provider told us they had fostered a good working relationship with the resuscitation team as it had highlighted a potential risk of more acutely unwell patients presenting to the service after the closure of the A&E department. Anaesthetic registrars employed by the hospital were due to visit the urgent care centre as part of their induction.

Are services safe?

- Staff received annual basic life support training and emergency medicines were easily accessible to staff in a secure area. All the medicines we checked were in date and stored securely. All staff we spoke with knew of their location.
- The service had two defibrillators available on the premises, one situated in the adult assessment bay and one in the child bay. We saw evidence that these were checked regularly. Flowing oxygen was available in both bays with adult and children's masks.
- A first aid kit and accident book were available.
- The service had a comprehensive business continuity plan (BCP) for major incidents such as power failure, evacuation, IT and telephony failure. Staff showed us a BCP box which contained a copy of the BCP, high visible jackets, a torch, mobile phone and medical note taking cards.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found the service assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best service guidelines.

- The service had systems in place to keep all clinical staff up-to-date. Staff we spoke with demonstrated that they could access guidelines from NICE and the local medicine formulary which was used when delivering care and treatment.
- The service monitored that these guidelines were followed through a random sample check of patients records.
- The provider had established monthly educational meetings for its clinical staff. Recent topics included mental health, fracture management, safeguarding and prescribing
- All patients presenting to the urgent care centre were booked in at reception. Reception staff had a process for prioritising patients with high risk symptoms, such as chest pain, shortness of breath or severe blood loss.
- Patients were then assessed to determine the appropriate 'stream'. The provider had refined its 'streaming' service model in November 2016 to reduce patient 'touch points' (the total interactions with healthcare professionals) to give a better patient journey and experience. All patients were assessed initially by a qualified clinical co-ordinator who undertook prioritisation assessment to 'stream' the patient into the appropriate treatment queue and prioritise urgency. This streaming process was categorised in three ways:
 1. Life or limb threatening illness or injury - transferred to A&E via 999 or on-site resuscitation support. The service told us the response time by the ambulance service was approximately eight minutes.
 2. Illness (urgent and non-urgent) - assessed, treated and discharged by a GP or advanced nurse practitioner.
 3. Injury (urgent and non-urgent) - assessed, treated and discharged by an advanced nurse practitioner or emergency care practitioner.

Management, monitoring and improving outcomes for people

The urgent care centre was contractually required to meet a range of quality and performance indicators and provide performance reports to the clinical commissioning group. Performance figures reported to the CCG showed the following:

- All patients attending the urgent care centre were triaged by a clinician who determined the care pathway for each patient. Targets for this were set as being within 15 minutes of arrival for children and within 20 minutes for adults with a target of 95%. Data for the period January 2016 to January 2017 showed that the provider had not met this target for any of the 12-month period reviewed for either children or adults. Achievement data for children ranged from 70% to 87% and for adults from 66% to 83%. The provider told us that the new 'streaming' service model introduced in November 2016 had impacted on this target. However, data reviewed for February and March 2017 showed that the provider was still not meeting the target for both children and adults. After the inspection the provider told us it had reviewed the data in detail to better understand why delays were occurring, when they were occurring and to calculate the actual variance from the target. We were told an action plan was being developed to ensure all initial assessments were carried out in the stipulated timeframes going forward. The provider had also audited its clinical incidents for the past 12 months to ensure none were related to any delay in the initial assessment. The provider confirmed it had found none.
- The service had a target that, after the definitive clinical assessment had begun, care must be completed within 4 hours in at least 95% of cases seen in the urgent care centre. The service had met this target every month for the period reviewed with achievement ranging from 98% to 100%.
- The service had a target that a minimum of 95% of patients would have an episode of care report to the GP within 48 hours of discharge of the patient. Data showed that this target had been met for the 12-month period reviewed.

We saw evidence of daily performance monitoring undertaken by the service including a day-to-day analysis. This ensured a comprehensive understanding of performance of the service was maintained. We reviewed 11 sets of anonymised patient notes during the inspection and found in all cases that patient care and the recording of it was appropriate.

Are services effective?

(for example, treatment is effective)

The centre carried out an ongoing programme of continuous audits which involved at least one audit per month. This included:

- An audit of at least one per cent of x-rays undertaken and interpreted. An audit undertaken in February 2016 revealed that one fracture had been missed. This was raised as a significant event. We saw evidence that the patient was recalled and an urgent fracture clinical appointment made. The provider told us that only clinicians with x-ray interpretation training were assigned to injury 'streaming.' This was confirmed by staff we spoke with on the day. The management team told us they would continue to include musculoskeletal and trauma topics at its clinical educational events. An audit undertaken in August 2016 showed that no fractures were missed.
- Review of one per cent of all patient consultations on a quarterly basis utilising the RCGP Urgent and Emergency Care Clinical Audit Toolkit 2010. Audit data showed compliance with outcomes between 93% and 95%.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The service had a comprehensive induction programme for newly appointed members of staff. We saw evidence on personnel files that newly appointed staff had completed the induction. The induction programme was tailored for clinical and non-clinical staff. The induction covered topics such as safeguarding, infection control and incident reporting.
- Training was managed through an intranet-based e-learning platform. Staff enrolled individually and the type of training, level and frequency was determined by their job role. Mandatory training included topics such as safeguarding, infection prevention and control, fire safety, health and safety, equality and diversity and information governance. Training included both e-learning and face-to-face. Staff were prompted through the e-learning platform when refresher training was due. The service manager maintained an overview of all mandatory training for both substantive and self-employed staff.
- The learning needs of staff were identified through a system of appraisals, audits, one-to-one meetings and reviews of service development needs. All staff had

received an appraisal within the last 12 months. This was in addition to the external GP appraisal and the national General Medical Council (GMC) revalidation process for GPs and the Midwifery Council (NMC) nurse revalidation process.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way, for example through the computerised clinical patient management system and their intranet system.

- The service shared relevant information with other services in a timely way. Where patients had used the services, a report detailing the care that they received was sent to the patient's GP by 8am the day following the consultation. A review of performance data showed that this had been achieved by the service every month in the year prior to the inspection.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred.
- There was internal access to the hospital diagnostics suite for x-rays 24-hours a day. Results were interpreted by the urgent care centre's clinicians and a formal report was provided by the hospital radiologist within 24 hours and 48 hours at weekends. Advice was also available from the on-call orthopaedic team at Northwick Park. Patients were also referred to the 'virtual' fracture clinic.
- The electronic record system enabled efficient communication with GP practices and other services.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005. We saw that clinical staff had undertaken consent, MCA and Deprivation of Liberty Standards (DoLS) training.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

Are services effective?

(for example, treatment is effective)

- Where a patient's mental capacity to consent to care or treatment was unclear the clinician assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

As an urgent care centre the service did not have the continuity of care to support patients to live healthier lives in the way that a GP practice would. Patients typically attended the service with acute episodes of minor illness or injuries requiring urgent attention. However, staff told us

they were committed to the promotion of good health and patient education. Healthcare promotion advice was available in the waiting room and on the provider's website.

Some patients attended the urgent care centre with exacerbations of long-term conditions or conditions which could readily be treated in general practice. The team discussed the challenge of transient patients in the area who were not registered with a local GP were using the service as their primary medical advice. Staff encouraged patients to register with a GP and provided information of local GPs with open patient lists.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- The facility was equipped with a number of curtained cubicles and individual consultation rooms. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We observed that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- Staff told us they were mindful of patient confidentiality, particularly in the curtained cubicles, and would move patients to a consulting room if a more sensitive issue needed to be discussed.
- The reception team sat within a glass reception cubicle with full visibility of the waiting area.

The clinician responsible for 'streaming' patients sat to one side of the reception cubicle and spoke with patients through a window hatch. This afforded privacy from patients queuing at reception and from those seated in the waiting area. Reception staff told us if a patient wanted to discuss a sensitive issue or appeared distressed they could offer them a private room to discuss their needs.

The provider gathered feedback from patients through a monthly survey adapted from the NHS Friends and Family Test (FFT). We reviewed responses received for December 2016, January 2017 and February 2017 and found the provider had received consistently positive feedback about the service. The most recent results available showed that:

December 2016 (186 completed surveys):

- 95% of patients would recommend the service to friends and family.
- 93% of patients reported being satisfied with their consultation.
- 93% of patients reported being treated with dignity and respect.

January 2017 (252 completed surveys):

- 98% of patients would recommend the service to friends and family.

- 91% of patients reported being satisfied with their consultation.
- 90% of patients reported being treated with dignity and respect.

February 2017 (182 completed surveys):

- 97% of patients would recommend the service to friends and family.
- 91% of patients reported being satisfied with their consultation.
- 92% of patients reported being treated with dignity and respect.

The provider had a contract key performance indicator (KPI) target to achieve a return rate of patient surveys of 3%. We saw that the provider had exceeded this target for the survey results reviewed: December 5%, January 8% and February 6%. They had achieved this by actively encouraging patients to complete feedback immediately after accessing the service.

Ten out of the 11 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the provider offered an excellent and efficient service and staff were helpful, caring and treated them with dignity and respect. The one negative comment was about the waiting time to be seen.

We spoke with three patients after their consultation during the inspection. Two of the patients had attended the service previously and for one it was the first time. All three patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. All the patients we spoke with were accessing the service during a period of low demand.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the monthly patient survey and the comment cards we received aligned with these views.

The service provided facilities to help patients be involved in decisions about their care:

Are services caring?

- Staff told us that interpretation services were available for patients who did not have English as a first language. The clinicians we spoke with on the day knew how to access these services.
- Information leaflets were available in easy read format. Information about the services provided by the urgent care centre were available in several languages, for example Arabic and Polish which was representative of the local population.

- Current health information was also available on the provider's website. The website had the facility to translate into other languages.

Patient and carer support to cope emotionally with care and treatment

Notices and patient information leaflets were available in the patient waiting area which told patients how to access a number of support groups and organisations.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The provider reviewed the needs of its local population and worked with the local clinical commissioning group (CCG) to secure improvements to services.

The service was responsive to patients' needs in a variety of ways:

- The urgent care centre was clearly signposted around the hospital and from the car park and the local bus service stopped directly outside.
- There were automatic doors leading to the main entrance and the service could also be accessed internally from the hospital. All areas of the service were accessible to patients with poor mobility.
- The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for access to consultation rooms and was visible from reception. There was enough seating for the number of patients who attended on the day of inspection. There were some smaller waiting areas away from the main waiting area which were also visible from reception.
- Toilets were available for patients attending the service including accessible facilities. An induction hearing loop was in place in the reception area.
- Children were assessed and treated as a priority and had a designated children's waiting area which was decorated and equipped in a child-friendly manner. Toilet facilities were available with baby changing equipment and breast feeding facilities.
- Interpreter services were available for patients whose first language was not English.
- A chaperone service was available and patients were able to see a clinician of the same gender if requested.
- Staff received training on equality and diversity which was part of the mandatory training schedule.
- The provider's website had the functionality to translate to other languages and leaflets about the service offered were available in other languages in the waiting room.

Access to the service

The urgent care centre offered care for walk-in patients with minor illness and injuries that needed urgent attention and was open 24 hours a day, seven days a week including bank holidays. Patients were able to access the service directly by self-presenting, or from their own GP or

after contacting NHS 111 (NHS 111 is a telephone-based service where callers are assessed, given advice and directed to a local service that most appropriately meets their needs). The service was provided primarily for patients living in the north west London borough of Brent but there were no restrictions to access. No patients were registered at the service as it was designed to meet the needs of patients who had an urgent medical concern but did not require accident and emergency treatment, such as non-life threatening conditions.

The urgent care centre was accessible externally from the car park or internally from the hospital and was well signed. There was clear internal signage which directed patients to the reception area. When a patient presented to reception details, such as name, date of birth, address and a brief reason for attending were recorded on the computer system. There were systems in place to determine any 'red flags' which might mean the patient needed to be seen by a clinician immediately. Reception staff we spoke with gave some examples which included chest pain, shortness of breath and severe blood loss. Children were also seen as a priority. Patients presenting underwent a clinical assessment ('streaming'). Patients assessed as suitable for treatment were 'streamed' to see a GP, advanced nurse practitioner or emergency care practitioner. The receptionists informed patients about anticipated waiting times. The provider had implemented this system following feedback from patients. Information was also displayed explaining that patients accessing the service were streamed through various pathways and so some patients may be seen more quickly than others.

Staff told us that on average three thousand patients were treated each month. We reviewed access data for December 2016, January 2017 and February 2017 and found:

- December 2016: 3439 cases of which 26% were injury cases and 74% were illness cases.
- January 2017: 3254 cases of which 27% were injury cases and 73% were illness cases.
- February 2017: 2796 cases of which 29% were injury cases and 71% were illness cases.

Listening and learning from concerns and complaints

The service had an effective system in place for handling complaints and concerns.

Are services responsive to people's needs?

(for example, to feedback?)

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for urgent care centres in England.
- There was a designated responsible person who handled all complaints in the service.
- We saw that information was available to help patients understand the complaints system in the waiting areas.
- The provider's website directed patients on how to feedback complaints and concerns by telephone, email and post.

We looked at 13 complaints received in the last 12 months. We saw that in all cases patients received a written

response, with details of the Ombudsman's office provided in case the complaint was not managed to the satisfaction of the patient. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. Learning from complaints was shared with staff on a one-to-one basis if required, through shared learning bulletins and also through the provider's newsletter if such learning needed to be shared more widely. Complaint reporting and outcomes were part of the monthly governance report provided to Care UK.

Are services well-led?

Good 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

The provider had a clear vision to deliver high quality care and promote good outcomes for patients. The management team told us they were passionate about giving patients the best possible care and helping them to feel better, faster.

- The provider had a corporate mission statement and service values and aims. Staff we spoke with knew and understood the values.
- The provider had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

There was an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear management structure at local level which included a service manager, GP lead and lead nurse. The local team were supported by Care UK's wider clinical governance structure which included a medical director and director of nursing. The conduit between the local team and Care UK was a regional quality governance manager for London. We saw there was structured governance, organisation and management oversight by Care UK. We saw evidence of monthly executive summaries which included total patients seen, patient feedback, audits undertaken, incidents and complaints and mandatory training compliance.
- Staff we spoke with were clear about the structure and were aware of their own roles and responsibilities.
- A comprehensive understanding of the performance of the service was maintained. Contract meetings were held monthly with the Brent CCG.
- Service specific policies were implemented and were available to all staff on the intranet. We saw that these were updated and reviewed regularly.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.

- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints. Learning from incidents was disseminated to staff locally through emails and significant incidents organisation-wide through a newsletter. We reviewed the latest edition and found it included a summary of incidents and complaints and medicines and prescription issues, guidance and updates.

Leadership and culture

On the day of inspection the management team demonstrated they had the experience, capacity and capability to run the service and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. The urgent care staff had an appropriate spread of skills and experience covering minor illness and injury. Staff told us the management team were approachable and always took the time to listen to all members of staff. Staff described the service manager as having an 'open door' policy.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The provider encouraged a culture of openness and honesty. We reviewed the significant events from the previous 12 months and found the provider had systems in place to ensure that when things went wrong with care and treatment the people affected received reasonable support, truthful information and a verbal and written apology.

Seeking and acting on feedback from patients, the public and staff

The provider encouraged and valued feedback from patients through a monthly patient survey. Feedback was consistently positive. For example, in February 2017, 182 surveys had been completed and 97% of patients said they would recommend the service to friends and family, 91% reported being satisfied with their consultation and 92% reported being treated with dignity and respect. The provider displayed feedback in the waiting area in a 'you said, we did' format.

Are services well-led?

Good 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

The provider obtained staff feedback through meetings and appraisals. We saw evidence of reception, nurse and clinician meetings. Staff told us they were able to give feedback and discuss any concerns or issues with colleagues and management. Staff we spoke with described a good team spirit.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the service. The service team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example:

- Refining the 'streaming' service model for patients presenting to the urgent care centre to reduce patient 'touch points' (the total interactions with healthcare professionals) to give a better patient journey and experience.
- Automating stock control for 'to take out' (TTO) medicines to reduce the risk of manual error and enable a more efficient medicines management system.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• The provider had not done all that was reasonably practicable to mitigate the risks to the health and safety of patients receiving care and treatment. In particular the service was failing to meet the target to triage and determine the care pathway for children and adults within the performance timeframe. <p>This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>